DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 1 1

2. STATE: New Mexico

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.50 (a) (1) (2)

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 39,521,000
b. FFY 2002 $ 39,521,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B
Page 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supercedes Current Page 2a

10. SUBJECT OF AMENDMENT:
Increases the Level 1 Common Procedural Terminology (CPT) Evaluation and Management Services, Surgery Services, Radiology Services, and Medicine Services Codes to 95% of the 2000 Medicare Fee Schedule, effective 10/01/2000.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Robert T. Maruca

14. TITLE:
Director, Medical Assistance Division

15. DATE SUBMITTED:
December 11, 2000

16. RETURN TO:
Robert T. Maruca, Director
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
JANUARY 12, 2001

18. DATE APPROVED:
MARCH 5, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCTOBER 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
CALVIN G. CLINE

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATION

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

7. Adjustments To Fee Schedule

When appropriations are made to adjust payment for physician services by the legislature, the appropriation will be applied to low paid procedures and to services for which access problems exist, or as otherwise directed by the appropriation following a public hearing on such adjustments.

a. Pursuant to State legislative appropriations, physician fees are increased effective March 1, 1996, for office-based Evaluation and Management Services, prenatal and obstetrical delivery services, and the medical screen of the Tot to Teen HealthCheck. Increased fees are based on the 1994 Medicare Participating Provider Fee Schedule. Routine global prenatal care and Cesarean delivery currently exceed the Medicare 1994 fee schedule, therefore the fees for these two services are increased 10 percent. The Tot to Teen HealthCheck is increased to $45.00.

b. Pursuant to State legislative appropriations, Level 1 Common Procedural Terminology (CPT) Evaluation and Management Services, Surgery Services, Radiology Services and Medicine Services codes are increased effective 10/01/2000 to 95% of the 2000 Medicare Fee Schedule.

b. A group practice is reimbursed at the rate payable to the individual performing physician or provider. For service for which a performing physician or provider is not identified, reimbursement will be made at the rate payable to the group.

c. Reimbursement for physician services furnished in hospital outpatient settings that are also ordinarily furnished in a physician's office is determined by using the Department's fee schedule for each professional service and multiplying the allowed amount by .60.

This reimbursement methodology is applicable only to physician's professional services in hospital outpatient settings (i.e., a hospital clinic, hospital office, the outpatient department). Excluded from this reimbursement methodology are services provided in rural health clinics, surgical services in an ambulatory setting, emergency services, anesthesiology services, diagnostic and therapeutic radiology services, and services provided by physicians who are compensated by or through the hospital and whose services are reimbursed on a compensation related charge basis. Services billed by physicians in teaching hospital whose Medicare Part B reimbursement is not based on a compensation related basis are subject to this methodology.

d. Payment for the professional component of a radiology service performed in an inpatient, outpatient, or office setting will not exceed 40 percent of the allowed amount.

SUPERSEDES: TN 96-03

STATE New Mexico	A
DATE REC'D 01-12-01	
DATE APPV'D 03 05 01	
DATE EFF 10-01-00	
HCFA I/A CC 011	